MassHealth

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Medical Necessity Review Form for Enteral Nutrition Products

All sections of this form must be completed by the prescriber and submitted with the MassHealth Prior Authorization Request. Providers should submit this form in place of the MassHealth General Prescription Form when requesting prior authorization for enteral nutrition products. Please refer to the instructions for completing this form provided at the end of this document. Please print or type all sections.

1. Member's name:	**2. Member's MassHealth ID no.:**	**3. Member's DOB:**
4. Member's address:		
5. Primary diagnosis:	**6. Secondary diagnosis:**	
7. Anthropometric measures (Complete all items.) ☐ Height: _____ ☐ Weight: _____ ☐ Growth percentile (child only): _____ ☐ Body mass index (BMI): _____ ☐ Basal metabolic rate (BMR): _____ ☐ Ideal body weight: _____	**8. Laboratory tests** (Attach results.) ☐ Type of blood tests (specify): _____ ☐ Type of urine tests (specify): _____ ☐ Other tests (specify): _____	
9. Risk factors (Use attachment as needed.) ☐ Anatomic structure of gastrointestinal tract ☐ Neurological disorder (specify): _____ ☐ Inborn errors of metabolism (specify): _____ ☐ Malabsorption syndrome (specify type): _____ ☐ Treatment with anti-nutrient or catabolic properties ☐ Increased metabolic or caloric need ☐ Other (specify): _____	**10. Route of treatment** ☐ Mouth (oral) only ☐ Nasogastric (NG-tube) ☐ Gastric (G-tube) ☐ Jejunal (J-tube) ☐ Other (specify): _____	
11. Treatment regimen initiated (Attach explanation.) ☐ Past ☐ Current (last six months) ☐ None	**12. Expected treatment outcome** (Attach explanation.) ☐ Expected to improve within 3 months ☐ Expected to improve within 6 months ☐ Expected to improve within 12 months ☐ Not expected to improve	
13. Location where member will use items: ☐ Home ☐ Work ☐ Other (specify):		
14. Duration of need (number of months):	**15. No. of refills**:	

16. Enteral formulae and supplies	**17. Calories per day from product**	**18. Quantity per month**
a.		
b.		
c.		
d.		

19. DME provider	
Company name:	MassHealth provider no. (if available):
Address:	Telephone no. (if available):

20. Prescriber	**21. Person completing form on behalf of prescriber**
Name:	Name:
Address:	Title:
Telephone no.:	Telephone no.:
MassHealth provider no.:	Organization:
Provider UPIN:	

22. Attestation: I certify that the clinical information provided on this form is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may be subject to civil or criminal liability.

_____ _____

Prescriber attestation (signature) **Date** (mm/dd/yy)

Instructions: Complete all applicable fields on the form. Print or type all sections.

Item 1	Member's name	Enter the member's name as it appears on the MassHealth card.
Item 2	Member's MassHealth ID no.	Enter the member's MassHealth identification number, which appears beside the member's name on the MassHealth card.
Item 3	Member's DOB	Enter the member's date of birth in month/day/year order.
Item 4	Member's address	Enter the member's permanent legal address (street address, town, and zip code).
Item 5	Primary diagnosis	Enter the primary diagnosis name and ICD-9-CM code that corresponds to the nutritional disorder for which the enteral product is being requested.
Item 6	Secondary diagnosis	Enter the secondary diagnosis name and ICD-9-CM codes (up to three codes) that further describe medical conditions associated with the primary diagnosis. Enter "N/A" if not applicable.
Item 7	Anthropometric measures	Complete all items associated with signs and symptoms of nutritional risk. Enter the member's height in inches, weight in pounds, body mass index, basal metabolic rate, and ideal body weight. Enter the growth percentile for children, and attach a growth chart.
Item 8	Laboratory tests	Place a checkmark beside all diagnostic laboratory tests that apply, and specify the type of tests (for example, serum albumin, hematocrit, and enzyme profiles) in the space provided. Attach the results for each test.
Item 9	Risk factors	Place a checkmark beside all risk factors that may affect treatment of nutritional risk. When indicated, specify the risk factors in the risk space provided. Attach clinical information for items checked.
Item 10	Route of treatment	Place a checkmark beside the primary method that enteral products will be administered. If checking "Other," specify the method (for example, gravity, pump, or syringe) in the space provided.
Item 11	Treatment regimen initiated	Place a checkmark beside treatments that have been tried to manage nutritional risk. Attach an explanation on other nutritional support products used and responsiveness to such treatments.
Item 12	Expected treatment outcome	Place a checkmark beside the item that describes the prognosis for improvement with enteral treatment. Attach an explanation.
Item 13	Location where member will use items	Place a checkmark beside all locations that apply to use of this product. If checking "Other," specify the location where the product will be used (for example, skilled nursing facility or end stage renal disease facility) in the space provided.
Item 14	Duration of need	Enter the total number of months that the prescriber expects the member to require use of the items requested. Specify 1 to 99 months, where 99 indicates lifetime use.
Item 15	No. of refills	Enter the number of monthly refills for this prescription.
Item 16	Enteral formulae and supplies	Print the name of the enteral formulae being requested and, if applicable, the supplies (for example, syringes or pump) required to administer the formulae.
Item 17	Calories per day from product	Enter the number of calories per day that the member is expected to obtain from enteral formulae listed.
Item 18	Quantity per month	Enter the quantity of enteral products requested per month for items listed (for example, 30 8-oz. cans).
Item 19	DME provider	Enter the company name and address of the provider who will supply the enteral product(s) being requested. If available, also provide the DME provider's telephone number and MassHealth provider number.
Item 20	Prescriber	Enter the physician's/clinician's name, address, and telephone number where he or she can be contacted if more information is needed. Include the prescriber's MassHealth provider number, or if the prescriber is not a MassHealth provider, enter the prescriber's unique physician identification number (UPIN).
Item 21	Person completing form on behalf of prescriber	If a clinical professional other than the treating clinician (for example, home health nurse, dietitian, physical therapist, or nursing facility staff) or a physician employee answers any of the items on this form, he or she must print his or her name, professional title, and name of employer (organization) where indicated.
Item 22	Attestation	The prescriber must attest that the clinical information provided on the form is accurate and complete to the best of the prescriber's knowledge by signing this field.

Note: Prior-authorization requests with incomplete medical necessity documentation may be returned for more information or denied. Please refer to the *MassHealth Guidelines for Medical Necessity Determination for Enteral Nutrition Products* for further information about submitting required clinical documentation.